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National Coalition on Health Care

"The Impact of Rising Health Care Cost on the Economy Fact Sheet Series"

Health Insurance Cost

This document is also available as a printable .pdf file.
Health Insurance Cost

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Facts on the Cost of Health Care

Introduction

By several measures, health care spending continues to rise at the fastest rate in our history.

In 2004 (the latest year data are available), total national health expenditures rose 7.9 percent -- over three times the rate of inflation (1). Total spending was $1.9 TRILLION in 2004, or $6,280 per person (1). Total health care spending represented 16 percent of the gross domestic product (GDP).

U.S. health care spending is expected to increase at similar levels for the next decade reaching $4 TRILLION in 2015, or 20 percent of GDP (2).

In 2006, employer health insurance premiums increased by 7.7 percent - two times the rate of inflation. The annual premium for an employer health plan covering a family of four averaged nearly $11,500. The annual premium for single coverage averaged over $4,200 (3).

Experts agree that our health care system is riddled with inefficiencies, excessive administrative expenses, inflated prices, poor management, and inappropriate care, waste and fraud. These problems significantly increase the cost of medical care and health insurance for employers and workers and affect the security of families.

National Health Care Spending

- In 2004, health care spending in the United States reached $1.9 trillion, and was projected to reach $2.9 trillion in 2009 (2). Health care spending is projected to reach $4 trillion by 2015 (2).
- Health care spending is 4.3 times the amount spent on national defense (4).
- In 2004, the United States spent 16 percent of its gross domestic product (GDP) on health care. It is projected that the percentage will reach 20 percent in the next decade (2).
- Although nearly 47 million Americans are uninsured, the United States spends more on health care than other industrialized nations, and those countries provide health insurance to all their citizens (4).
- Health care spending accounted for 10.9 percent of the GDP in Switzerland, 10.7 percent in Germany, 9.7 percent in Canada and 9.5 percent in France, according to the Organization for Economic Cooperation and Development (5).

Employer and Employee Health Insurance Costs

- Premiums for employer-based health insurance rose by 7.7 percent in 2006. Small employers saw their premiums, on average, increase 8.8 percent. Firms with less than 24 workers, experienced an increase of 10.5 percent (3)
- The annual premium that a health insurer charges an employer for a health plan covering a family of four averaged $11,500 in 2006. Workers contributed nearly $3,000, or 10 percent more than they did in 2005 (3).The annual premiums for family coverage significantly eclipsed the gross earnings for a full-time, minimum-wage worker ($10,712).
- Workers are now paying $1,094 more in premiums annually for family coverage than they did in 2000 (3).

- Since 2000, employment-based health insurance premiums have increased 87 percent, compared to cumulative inflation of 18 percent and cumulative wage growth of 20 percent during the same period (3).
- Health insurance expenses are the fastest growing cost component for employers. Unless something changes dramatically, health insurance costs will overtake profits by 2008 (6).
- According to the Kaiser Family Foundation and the Health Research and Educational Trust, premiums for employer-sponsored health insurance in the United States have been rising four times faster on average than workers' earnings since 2000 (3).
- The average employee contribution to company-provided health insurance has increased more than 143 percent since 2000. Average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits rose 115 percent during the same period (7).
- The percentage of Americans under age 65 whose family-level, out-of-pocket spending for health care, including health insurance, that exceeds $2,000 a year, rose from 37.3 percent in 1996 to 43.1 percent in 2003 - a 16 percent increase (8).

The Impact of Rising Health Care Costs

- National surveys show that the primary reason people are uninsured is the high cost of health insurance coverage (9).
- Economists have found that rising health care costs correlate to drops in health insurance coverage (10).
- Nearly one-quarter (23 percent) of the uninsured reported changing their way of life significantly in order to pay medical bills (10).
- Almost 50 percent of the American public say they are very worried about having to pay more for their health care or health insurance, while 42 percent report they are very worried about not being able to afford health care services (11).
- In a poll conducted by the Harvard School of Public Health, 43 percent of respondents named high costs as one of the two most important health care issues for government to address (12).
- In a USA Today/ABC News survey, 80 percent of Americans said that they were dissatisfied (60 percent were very dissatisfied) with high national health care spending (13).
- One in four Americans say their family has had a problem paying for medical care during the past year, up 7 percentage points over the past nine years. Nearly 30 percent say someone in their family has delayed medical care in the past year, a new high based on recent polling. Most say the medical condition was at least somewhat serious (13).
- A recent study by Harvard University researchers found that the average out-of-pocket medical debt for those who filed for bankruptcy was $12,000. The study noted that 68 percent of those who filed for bankruptcy had health insurance. In addition, the study found that 50 percent of all bankruptcy filings were partly the result of medical expenses (14). Every 30 seconds in the United States someone files for bankruptcy in the aftermath of a serious health problem.
- One half of workers in the lowest-compensation jobs and one-half of workers in mid-range-compensation jobs either had problems with medical bills in a 12-month period or were paying off accrued debt. One-quarter of workers in higher-compensated positions also reported problems with medical bills or were paying off accrued debt (15).
- If one member of a family is uninsured and has an accident, a hospital stay, or a costly medical treatment, the resulting medical bills can affect the economic stability of the whole family (16).
- A new survey shows that more than 25 percent said that housing problems resulted from medical debt, including the inability to make rent or mortgage payments and the development of bad credit ratings (17).
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- A survey of Iowa consumers found that in order to cope with rising health insurance costs, 86 percent said they had cut back on how much they could save, and 44 percent said that they have cut back on food and heating expenses (18).
- Retiring elderly couples will need $200,000 in savings just to pay for the most basic medical coverage (19). Many experts believe that this figure is conservative and that $300,000 may be a more realistic number.

Time for Action on Reining in Health Care Costs

Policymakers and government officials agree that health care costs must be controlled. But they disagree on the best ways to address rapidly escalating health spending and health insurance premiums. Some favor price controls and imposing strict budgets on health care spending. Others believe free market competition is the best way to solve the problems. Public health advocates believe that if all Americans adopted healthy lifestyles, health care costs would decrease as people required less medical care.

There appears to be no agreement on a single solution to health care's high price tag. Many approaches may be used to control costs. What we do know is if the rate of escalation in health care spending and health insurance premiums continues at current trends, the cost of inaction will severely affect employer's bottom lines and consumer's pocketbooks.

Notes

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(b) For the period on and after October 16, 2003:

(1) *Retail pharmacy drug claims.* The National Council for Prescription Drug Programs Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunications Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record. (Incorporated by reference in §162.920).

(2) *Dental health care claims.* The ASC X12N 837—Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1. (Incorporated by reference in §162.920).

(3) *Professional health care claims.* The ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1. (Incorporated by reference in §162.920).

(4) *Institutional health care claims.* The ASC X12N 837—Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1. (Incorporated by reference in §162.920).

[68 FR 8399, Feb. 20, 2003]

PART 163 [RESERVED]

PART 164—SECURITY AND PRIVACY

Subpart A—General Provisions

Sec.

Subpart B [Reserved]

Subpart C—Security Standards for the Protection of Electronic Protected Health Information

Subpart D [Reserved]

Subpart E—Privacy of Individually Identifiable Health Information

AUTHORITY: 42 U.S.C. 1320d–1320d–8 and sec. 264, Pub. L. No. 104–191, 110 Stat. 2033–2034 (42 U.S.C. 1320d–2 (note)).

SOURCE: 65 FR 82802, Dec. 28, 2000, unless otherwise noted.

Standards	Sections	Implementation Specifications (R)=Required, (A)=Addressable
		Encryption (A)

Subpart D [Reserved]

Subpart E—Privacy of Individually Identifiable Health Information

AUTHORITY: 42 U.S.C. 1320d–2 and 1320d–4, sec. 264 of Pub. L. 104–191, 110 Stat. 2033–2034 (42 U.S.C. 1320d–2(note)).

§ 164.500 Applicability.

(a) Except as otherwise provided herein, the standards, requirements, and implementation specifications of this subpart apply to covered entities with respect to protected health information.

(b) Health care clearinghouses must comply with the standards, requirements, and implementation specifications as follows:

(1) When a health care clearinghouse creates or receives protected health information as a business associate of another covered entity, the clearinghouse must comply with:

(i) Section 164.500 relating to applicability;

(ii) Section 164.501 relating to definitions;

(iii) Section 164.502 relating to uses and disclosures of protected health information, except that a clearinghouse is prohibited from using or disclosing protected health information other than as permitted in the business associate contract under which it created or received the protected health information;

(iv) Section 164.504 relating to the organizational requirements for covered entities;

(v) Section 164.512 relating to uses and disclosures for which individual authorization or an opportunity to agree or object is not required, except that a clearinghouse is prohibited from using or disclosing protected health information other than as permitted in the business associate contract under which it created or received the protected health information;

(vi) Section 164.532 relating to transition requirements; and

(vii) Section 164.534 relating to compliance dates for initial implementation of the privacy standards.

(2) When a health care clearinghouse creates or receives protected health information other than as a business associate of a covered entity, the clearinghouse must comply with all of the standards, requirements, and implementation specifications of this subpart.

(c) The standards, requirements, and implementation specifications of this subpart do not apply to the Department of Defense or to any other federal agency, or non-governmental organization acting on its behalf, when providing health care to overseas foreign national beneficiaries.

[65 FR 82802, Dec. 28, 2000, as amended at 67 FR 53266, Aug. 14, 2002; 68 FR 8381, Feb. 20, 2003]

§ 164.501 Definitions.

As used in this subpart, the following terms have the following meanings:

Correctional institution means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. *Other persons* held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.

Data aggregation means, with respect to protected health information created or received by a business associate in its capacity as the business associate of a covered entity, the combining of such protected health information by the business associate with

(2) *Implementation specification: documentation.* A covered entity must document the satisfactory assurances required by paragraph (e)(1) of this section through a written contract or other written agreement or arrangement with the business associate that meets the applicable requirements of §164.504(e).

(f) *Standard: Deceased individuals.* A covered entity must comply with the requirements of this subpart with respect to the protected health information of a deceased individual.

(g)(1) *Standard: Personal representatives.* As specified in this paragraph, a covered entity must, except as provided in paragraphs (g)(3) and (g)(5) of this section, treat a personal representative as the individual for purposes of this subchapter.

(2) *Implementation specification: adults and emancipated minors.* If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation.

(3)(i) *Implementation specification: unemancipated minors.* If under applicable law a parent, guardian, or other person acting *in loco parentis* has authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation, except that such person may not be a personal representative of an unemancipated minor, and the minor has the authority to act as an individual, with respect to protected health information pertaining to a health care service, if:

(A) The minor consents to such health care service; no other consent to such health care service is required by law, regardless of whether the consent of another person has also been obtained; and the minor has not requested that such person be treated as the personal representative;

(B) The minor may lawfully obtain such health care service without the consent of a parent, guardian, or other person acting *in loco parentis*, and the minor, a court, or another person authorized by law consents to such health care service; or

(C) A parent, guardian, or other person acting *in loco parentis* assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.

(ii) Notwithstanding the provisions of paragraph (g)(3)(i) of this section:

(A) If, and to the extent, permitted or required by an applicable provision of State or other law, including applicable case law, a covered entity may disclose, or provide access in accordance with §164.524 to, protected health information about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis*;

(B) If, and to the extent, prohibited by an applicable provision of State or other law, including applicable case law, a covered entity may not disclose, or provide access in accordance with §164.524 to, protected health information about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis*; and

(C) Where the parent, guardian, or other person acting *in loco parentis*, is not the personal representative under paragraphs (g)(3)(i)(A), (B), or (C) of this section and where there is no applicable access provision under State or other law, including case law, a covered entity may provide or deny access under §164.524 to a parent, guardian, or other person acting *in loco parentis*, if such action is consistent with State or other applicable law, provided that such decision must be made by a licensed health care professional, in the exercise of professional judgment.

(4) *Implementation specification: Deceased individuals.* If under applicable law an executor, administrator, or other person has authority to act on behalf of a deceased individual or of the individual's estate, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation.

(5) *Implementation specification: Abuse, neglect, endangerment situations.* Notwithstanding a State law or any requirement of this paragraph to the contrary, a covered entity may elect not to treat a person as the personal representative of an individual if:

(i) The covered entity has a reasonable belief that:

(A) The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or

(B) Treating such person as the personal representative could endanger the individual; and

(ii) The covered entity, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.

(h) *Standard: Confidential communications.* A covered health care provider or health plan must comply with the applicable requirements of §164.522(b) in communicating protected health information.

(i) *Standard: Uses and disclosures consistent with notice.* A covered entity that is required by §164.520 to have a notice may not use or disclose protected health information in a manner inconsistent with such notice. A covered entity that is required by §164.520(b)(1)(iii) to include a specific statement in its notice if it intends to engage in an activity listed in §164.520(b)(1)(iii)(A)–(C), may not use or disclose protected health information for such activities, unless the required statement is included in the notice.

(j) *Standard: Disclosures by whistleblowers and workforce member crime victims*—(1) *Disclosures by whistleblowers.* A covered entity is not considered to have violated the requirements of this subpart if a member of its workforce or a business associate discloses protected health information, provided that:

(i) The workforce member or business associate believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public; and

(ii) The disclosure is to:

(A) A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the covered entity; or

(B) An attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate with regard to the conduct described in paragraph (j)(1)(i) of this section.

(2) *Disclosures by workforce members who are victims of a crime.* A covered entity is not considered to have violated the requirements of this subpart if a member of its workforce who is the victim of a criminal act discloses protected health information to a law enforcement official, provided that:

(i) The protected health information disclosed is about the suspected perpetrator of the criminal act; and

(ii) The protected health information disclosed is limited to the information listed in §164.512(f)(2)(i).

[65 FR 82802, Dec. 28, 2000, as amended at 67 FR 53267, Aug. 14, 2002]

§164.504 Uses and disclosures: Organizational requirements.

(a) *Definitions.* As used in this section:

Plan administration functions means administration functions performed by the plan sponsor of a group health plan on behalf of the group health plan and excludes functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

Summary health information means information, that may be individually identifiable health information, and:

(1) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

(2) From which the information described at §164.514(b)(2)(i) has been deleted, except that the geographic information described in §164.514(b)(2)(i)(B)

need only be aggregated to the level of a five digit zip code.

(b)–(d)

(e)(1) *Standard: Business associate contracts.* (i) The contract or other arrangement between the covered entity and the business associate required by §164.502(e)(2) must meet the requirements of paragraph (e)(2) or (e)(3) of this section, as applicable.

(ii) A covered entity is not in compliance with the standards in §164.502(e) and paragraph (e) of this section, if the covered entity knew of a pattern of activity or practice of the business associate that constituted a material breach or violation of the business associate's obligation under the contract or other arrangement, unless the covered entity took reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful:

(A) Terminated the contract or arrangement, if feasible; or

(B) If termination is not feasible, reported the problem to the Secretary.

(2) *Implementation specifications: Business associate contracts.* A contract between the covered entity and a business associate must:

(i) Establish the permitted and required uses and disclosures of such information by the business associate. The contract may not authorize the business associate to use or further disclose the information in a manner that would violate the requirements of this subpart, if done by the covered entity, except that:

(A) The contract may permit the business associate to use and disclose protected health information for the proper management and administration of the business associate, as provided in paragraph (e)(4) of this section; and

(B) The contract may permit the business associate to provide data aggregation services relating to the health care operations of the covered entity.

(ii) Provide that the business associate will:

(A) Not use or further disclose the information other than as permitted or required by the contract or as required by law;

(B) Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by its contract;

(C) Report to the covered entity any use or disclosure of the information not provided for by its contract of which it becomes aware;

(D) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from, or created or received by the business associate on behalf of, the covered entity agrees to the same restrictions and conditions that apply to the business associate with respect to such information;

(E) Make available protected health information in accordance with §164.524;

(F) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with §164.526;

(G) Make available the information required to provide an accounting of disclosures in accordance with §164.528;

(H) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the business associate on behalf of, the covered entity available to the Secretary for purposes of determining the covered entity's compliance with this subpart; and

(I) At termination of the contract, if feasible, return or destroy all protected health information received from, or created or received by the business associate on behalf of, the covered entity that the business associate still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(iii) Authorize termination of the contract by the covered entity, if the covered entity determines that the business associate has violated a material term of the contract.

(3) *Implementation specifications: Other arrangements.* (i) If a covered entity and

its business associate are both governmental entities:

(A) The covered entity may comply with paragraph (e) of this section by entering into a memorandum of understanding with the business associate that contains terms that accomplish the objectives of paragraph (e)(2) of this section.

(B) The covered entity may comply with paragraph (e) of this section, if other law (including regulations adopted by the covered entity or its business associate) contains requirements applicable to the business associate that accomplish the objectives of paragraph (e)(2) of this section.

(ii) If a business associate is required by law to perform a function or activity on behalf of a covered entity or to provide a service described in the definition of *business associate* in §160.103 of this subchapter to a covered entity, such covered entity may disclose protected health information to the business associate to the extent necessary to comply with the legal mandate without meeting the requirements of this paragraph (e), provided that the covered entity attempts in good faith to obtain satisfactory assurances as required by paragraph (e)(3)(i) of this section, and, if such attempt fails, documents the attempt and the reasons that such assurances cannot be obtained.

(iii) The covered entity may omit from its other arrangements the termination authorization required by paragraph (e)(2)(iii) of this section, if such authorization is inconsistent with the statutory obligations of the covered entity or its business associate.

(4) *Implementation specifications: Other requirements for contracts and other arrangements.* (i) The contract or other arrangement between the covered entity and the business associate may permit the business associate to use the information received by the business associate in its capacity as a business associate to the covered entity, if necessary:

(A) For the proper management and administration of the business associate; or

(B) To carry out the legal responsibilities of the business associate.

(ii) The contract or other arrangement between the covered entity and the business associate may permit the business associate to disclose the information received by the business associate in its capacity as a business associate for the purposes described in paragraph (e)(4)(i) of this section, if:

(A) The disclosure is required by law; or

(B)(*1*) The business associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and

(*2*) The person notifies the business associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(f)(1) *Standard: Requirements for group health plans.* (i) Except as provided under paragraph (f)(1)(ii) or (iii) of this section or as otherwise authorized under §164.508, a group health plan, in order to disclose protected health information to the plan sponsor or to provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO with respect to the group health plan, must ensure that the plan documents restrict uses and disclosures of such information by the plan sponsor consistent with the requirements of this subpart.

(ii) The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose summary health information to the plan sponsor, if the plan sponsor requests the summary health information for the purpose of :

(A) Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or

(B) Modifying, amending, or terminating the group health plan.

(iii) The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose to the plan sponsor information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a

agencies is required or expressly authorized by statute or regulation.

(ii) A covered entity that is a government agency administering a government program providing public benefits may disclose protected health information relating to the program to another covered entity that is a government agency administering a government program providing public benefits if the programs serve the same or similar populations and the disclosure of protected health information is necessary to coordinate the covered functions of such programs or to improve administration and management relating to the covered functions of such programs.

(l) *Standard: Disclosures for workers' compensation.* A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

[65 FR 82802, Dec. 28, 2000, as amended at 67 FR 53270, Aug. 14, 2002]

§ 164.514 Other requirements relating to uses and disclosures of protected health information.

(a) *Standard: de-identification of protected health information.* Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

(b) *Implementation specifications: requirements for de-identification of protected health information.* A covered entity may determine that health information is not individually identifiable health information only if:

(1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

(i) Applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

(ii) Documents the methods and results of the analysis that justify such determination; or

(2)(i) The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(*1*) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(*2*) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;

(E) Fax numbers;

(F) Electronic mail addresses;

(G) Social security numbers;

(H) Medical record numbers;

(I) Health plan beneficiary numbers;

(J) Account numbers;

(K) Certificate/license numbers;

(L) Vehicle identifiers and serial numbers, including license plate numbers;

(M) Device identifiers and serial numbers;

(N) Web Universal Resource Locators (URLs);

(O) Internet Protocol (IP) address numbers;

(P) Biometric identifiers, including finger and voice prints;

(Q) Full face photographic images and any comparable images; and

(R) Any other unique identifying number, characteristic, or code, except

as permitted by paragraph (c) of this section; and

(ii) The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

(c) *Implementation specifications: re-identification.* A covered entity may assign a code or other means of record identification to allow information de-identified under this section to be re-identified by the covered entity, provided that:

(1) *Derivation.* The code or other means of record identification is not derived from or related to information about the individual and is not otherwise capable of being translated so as to identify the individual; and

(2) *Security.* The covered entity does not use or disclose the code or other means of record identification for any other purpose, and does not disclose the mechanism for re-identification.

(d)(1) *Standard: minimum necessary requirements.* In order to comply with §164.502(b) and this section, a covered entity must meet the requirements of paragraphs (d)(2) through (d)(5) of this section with respect to a request for, or the use and disclosure of, protected health information.

(2) *Implementation specifications: minimum necessary uses of protected health information.* (i) A covered entity must identify:

(A) Those persons or classes of persons, as appropriate, in its workforce who need access to protected health information to carry out their duties; and

(B) For each such person or class of persons, the category or categories of protected health information to which access is needed and any conditions appropriate to such access.

(ii) A covered entity must make reasonable efforts to limit the access of such persons or classes identified in paragraph (d)(2)(i)(A) of this section to protected health information consistent with paragraph (d)(2)(i)(B) of this section.

(3) *Implementation specification: Minimum necessary disclosures of protected health information.* (i) For any type of disclosure that it makes on a routine and recurring basis, a covered entity must implement policies and procedures (which may be standard protocols) that limit the protected health information disclosed to the amount reasonably necessary to achieve the purpose of the disclosure.

(ii) For all other disclosures, a covered entity must:

(A) Develop criteria designed to limit the protected health information disclosed to the information reasonably necessary to accomplish the purpose for which disclosure is sought; and

(B) Review requests for disclosure on an individual basis in accordance with such criteria.

(iii) A covered entity may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when:

(A) Making disclosures to public officials that are permitted under §164.512, if the public official represents that the information requested is the minimum necessary for the stated purpose(s);

(B) The information is requested by another covered entity;

(C) The information is requested by a professional who is a member of its workforce or is a business associate of the covered entity for the purpose of providing professional services to the covered entity, if the professional represents that the information requested is the minimum necessary for the stated purpose(s); or

(D) Documentation or representations that comply with the applicable requirements of §164.512(i) have been provided by a person requesting the information for research purposes.

(4) *Implementation specifications: Minimum necessary requests for protected health information.* (i) A covered entity must limit any request for protected health information to that which is reasonably necessary to accomplish the purpose for which the request is made, when requesting such information from other covered entities.

(ii) For a request that is made on a routine and recurring basis, a covered entity must implement policies and procedures (which may be standard protocols) that limit the protected health information requested to the

AUTHORIZATION FOR USE AND DISCLOSURE OF AN INDIVIDUAL'S PROTECTED HEALTH INFORMATION

This Authorization is executed by or on behalf of the Beneficiary designated below who is eligible to receive benefits under the State Bar of Montana Group Benefits Plan ("Benefits Plan"). The Beneficiary hereby authorizes the use and disclosure of the Beneficiary's protected health information identified in Section II of this Authorization in accordance with terms of this Authorization:

Name of Beneficiary:_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

SECTION I. This Authorization is directed to and delivered to each of the following parties and their respective employees, agents and representatives for the purposes stated herein:

A. Trustees of the State Bar of Montana Group Benefits Trust ("Trustees")
c/o Bernard McCarthy, Chair
P.O. Box 523
Whitehall, MT 59759

B. State Bar of Montana ("SBM")
c/o Chris Manos, Executive Director
7 West 6th Avenue, Suite 2B
Helena, MT 59601

C. Blue Cross and Blue Shield of Montana ("BCBS")
560 North Park Avenue
P.O. Box 4309
Helena, MT 59604-4309

SECTION II. This Authorization applies to any and all of the following protected health information pertaining to the Beneficiary which may be in the possession of the Trustees, SBM or BCBS:

A. Services and Benefits. Data, records and information, including the Beneficiary's medical records and documents, which relate to any health care services, benefits or products received by the Beneficiary.

B. Claims Information. Claims data, claims records and claims information of any kind or nature related to the receipt or payment of claims for health care services, benefits or products received by the Beneficiary, including any data, records or information located on a claims record.

C. Authorization Information. Information regarding precertifications and authorizations, including specific medical information related to requests and determinations.

D. Premium Information. Information relating to premiums, rates and billings cycles for any benefits or coverages which the Beneficiary is or was eligible to receive under the Benefits Plan.

SECTION III. The information described in Section II may be used by and disclosed to Western States Insurance Agency, whose address is 2925 Palmer Street, Suite B, P.O. Box 4386, Missoula, MT 59806. In addition, the information described in Section II may be used by and disclosed the any or more of the following health insurance companies (and their respective employees, agents and representatives) which ALPS Corporation may hereafter designate in writing to BCBS:

BLUE CROSS AND BLUE SHIELD OF MONTANA ("BCBS")
560 North Park Avenue
P.O. Box 4309
Helena, MT 59604-4309

PRINCIPAL 711 High Street Des Moines IA 50392-0001	FORTIS BENEFITS 1512 Plaza, 600 Building Seattle WA 98101	GREAT WEST LIFE 3005 112th Ave., N.E. Suite 200 Bellevue, WA 98004

CORPORATE BENEFIT SERVICES OF AMERICAN, INC.
10159 Wayzata Blvd
Minnetonka, MN 55305

Each of the foregoing health insurance companies are each separately referred to herein as "Health Insurance Company" or collectively referred to herein as "Health Insurance Companies."

SECTION IV. ALPS Corporation desires to obtain group health insurance underwriting, ratings and premium quotations from any one or more of the Health Insurance Companies identified in Section III. The information described in Section II may be used by and disclosed to Western States Insurance Agency and to each Health Insurance Company identified in Section III for the purposes of allowing ALPS Corporation to obtain underwriting, ratings and premium quotations from any one or more of the Health Insurance Companies with respect to any health and welfare benefit plans, products or services offered by each respective Health Insurance Company.

SECTION V. This Authorization is valid until and shall expire at midnight on December 31, 2004.

SECTION VI. The individual executing this Authorization states that:

A. I understand that I may refuse to sign this Authorization and that my refusal will not affect the ability to obtain treatment, payment or eligibility for benefits with the Benefits Plan or any other BCBS plan, product or service.

B. I understand that I may revoke this Authorization at any time in writing, except to the extent that the information described in Section II has already been used by or disclosed to a Health Insurance Company for the purposes stated in this Authorization. To revoke this Authorization, I can deliver a written revocation to any of the Trustees, SBA or BCBS at the respective addresses set forth in Section I above.

C. I understand that this Authorization is not valid without the required signature below.

D. I understand that the recipient of the information described in Section II may possibly re-disclose the information to others without my knowledge and authorization; therefore, the applicable privacy laws and regulations may no longer apply to the information.

Signature Page of Authorization for Use and Disclosure

THIS AUTHORIZATION is signed this _____ day of _____, 2003.

Print Name:_____

Signature:_____

If you are signing in a representative capacity on behalf of the Beneficiary, please indicate your relationship to the Beneficiary or your authority to sign on behalf of the Beneficiary in a representative capacity (*Please Check One*):

Parent of Minor Child _____

Legal Guardian _____

Power of Attorney _____

Other (please state) _____

health information other than as permitted or required by the plan documents or as required by law; (2) ensure that any subcontractors or agents to whom the plan sponsor provides protected health information agree to the same restrictions; (3) not use or disclose the protected health information for employment-related actions; (4) report to the group health plan any use or disclosure that is inconsistent with the plan documents or this regulation; (5) make the protected health information accessible to individuals; (6) allow individuals to amend their information; (7) provide an accounting of its disclosures; (8) make its practices available to the Secretary for determining compliance; (9) return and destroy all protected health information when no longer needed, if feasible; and (10) ensure that the firewalls have been established.

We have included this certification requirement in part, as a way to reduce the burden on health insurance issuers and HMOs. Without a certification, health insurance issuers and HMOs would need to review the plan documents in order to ensure that the amendments have been made before they could disclose protected health information to plan sponsors. The certification, however, is a simple statement that the amendments have been made and that the plan sponsor has agreed to certain restrictions on the use and disclosure of protected health information. The receipt of the certification therefore, is sufficient basis for the health insurance issuer or HMO to disclose protected health information to the plan sponsor.

Many activities included in the definitions of health care operations and payment are commonly referred to as plan administration functions in the ERISA group health plan context. For purposes of this rule, plan administration activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the plan or solicit bids from prospective issuers. Plan administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans — such as vision and dental. Under the final rule, "plan administration" does not include any employment-related functions or functions in connection with any other benefits or benefit plans, and group health plans may not disclose information for such purposes absent an authorization from the individual. For purposes of this rule, enrollment functions performed by the plan sponsor on behalf of its employees are not considered plan administration functions.

Plan sponsors have access to protected health information only to the extent group health plans have access to protected health information and plan sponsors are permitted to use or disclose protected health information only as would be permitted by group health plans. That is, a group health plan may permit a plan sponsor to have access to or to use protected health information only for purposes allowed by the regulation.

As explained above, where a group health plan purchases insurance or coverage from a health insurance issuer or HMO, the provision of insurance or coverage by the health insurance issuer or HMO to the group health plan does not make the health insurance issuer or HMO a business associate. In such case, the activities of the health insurance issuer or HMO are on their own behalf and not on the behalf of the group health plan. We note that where a group health plan contracts with a health insurance issuer or HMO to perform functions or activities or to provide services that are in addition to or not directly related to the provision of insurance, the health insurance issuer or HMO may be a business associate with respect to those additional functions, activities, or services. In addition, group health plans that provide health benefits only through an insurance contract and do not create, maintain, or receive protected health information (except for summary information described below or information that merely states whether an individual is enrolled in or has been disenrolled from the plan) do not have to meet the notice requirements of §164.520 or the administrative requirements of §164.530, except for the documentation requirement in §164.530(j), because these requirements are satisfied by the issuer or HMO that is providing benefits under the group health plan. A group health plan, however, may not permit a health insurance issuer or HMO to disclose protected health information to a plan sponsor unless the notice required in 164.520 indicate such disclosure may occur.

The final rule also permits a health plan that is providing insurance to a group health plan to provide summary information to the plan sponsor to permit the plan sponsor to solicit premium bids from other health plans or for the purpose of modifying, amending, or terminating the plan. The rule provides that summary information is information that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the plan sponsor has provided health benefits under a group health plan, provided that specified identifiers are not included. Summary information may be disclosed under this provision even if it does not meet the definition of de-identified information. As part of the notice requirements in §164.520, health plans must inform individuals that they may disclose protected health information to plan sponsors. The provision to allow summaries of claims experience to be disclosed to plan sponsors that purchase insurance will allow them to shop for replacement coverage, and get meaningful bids from prospective issuers. It also permits a plan sponsor to get summary information as part of its consideration of whether or not to change the benefits that are offered or employees or whether or not to terminate a group health plan.

We note that a plan sponsor may perform enrollment functions on behalf of its employees without meeting the conditions above and without using the

